

INSTRUCTIONS:

ATTACH THIS FORM TO THE APPLICATION FOR SICK LEAVE OR INJURY PAY (CBP-156) AND FORWARD BOTH TO THE CITY SERVICE COMMISSION.

CITY OF MILWAUKEE

CBP-157

SICK LEAVE CERTIFICATION

Date _____

I hereby certify that _____
(NAME OF PATIENT)

has been under my care on account of (*State nature of illness or injury*)

and has been unable to perform his regular city duties as _____

_____ for the period
(TITLE OF POSITION)

From: _____ 20 ____ To: _____ 20 ____ Inc.

Signed _____

Address _____